

**DEPARTMENT OF MANAGED HEALTH CARE  
CALIFORNIA HMO HELP CENTER  
DIVISION OF PLAN SURVEYS**

**MENTAL HEALTH PARITY FOCUSED SURVEY  
FINAL REPORT**

**Health Net of California, Inc.  
Managed Health Network, Inc.**

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*Health Net of California, Inc.*  
*Mental Health Parity Focused Survey Final Report*  
*November 10, 2005*

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## EXECUTIVE SUMMARY

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The California Department of Managed Health Care (the “Department”) conducted a Focused Survey of Health Net of California, Inc., (the “Plan”) and Managed Health Network, Inc., (the “Delegate”) from May 9, 2005, to May 12, 2005. A “focused survey” assesses compliance of a particular aspect of plan operations with the Knox-Keene Health Care Service Plan Act of 1975 (“Knox-Keene”). In this case, the Focused Survey assessed compliance of the Plan’s delivery of mental health services. (Section 1374.72 of the Health and Safety Code, Severe mental illnesses; serious emotional disturbances of children)

Health Net of California, Inc., was the fourth focused survey completed of seven focused surveys scheduled between March and June 2005. Plans that were surveyed are Knox-Keene licensed full service plans, and if applicable, specialty mental health plan delegates that administer and provide mental health benefits and services on behalf of the full service plan.

Health and Safety Code Section 1374.72, often referred to as the “**Parity Act**,” requires full-service health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Section 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and ensure the continuity and coordination of care provided to enrollees.

The Plan delegates the provision of mental health services to its Delegate, Managed Health Network, Inc. The Delegate provides mental health services to 97 percent of the Plan’s enrollees. (See Appendix B)

### **Background**

#### **Health Net of California, Inc.**

Health Net of California, Inc., was founded as a non-profit California corporation in 1977. In 1979, it was licensed by the California Department of Insurance as a hospital service plan and was approved as a federally qualified health maintenance organization (HMO).

In 1994, Health Net merged with QualMed Plans for Health and the new company was called Health Systems International (HSI). The merger included QualMed Plans’ operations in six states other than California. In April 1997, HSI merged with Foundation Health Corporation (FHC) under the new corporate name Foundation Health System, Inc. In California, Health Net and Foundation’s California subsidiary, Foundation Health Plan, merged in January 1998. In November 2000, Foundation Health System changed its name to Health Net, Inc., and Health Net became Health Net of California, Inc., a publicly traded company.

In 2002, Health Net, Inc., centralized the following functions for all of its Health Net subsidiaries: customer call center, Health Plan Employer Data and Information Set (HEDIS)<sup>®</sup> data collection and analysis, pharmacy management, credentialing, claims processing, information technology, and wellness/prevention programs.

### **Managed Health Network**

Managed Health Network (MHN) was created by the merger of Brownlee Dolan Stein and The Human Resources Group, which specialized in employee assistance programs, with the California Wellness Plan in 1987. It became licensed as a Knox-Keene specialty care HMO. In March 1996, Foundation Health Corporation acquired MHN. Subsequent to the acquisition, MHN merged with Foundation Health Corporation's behavioral health subsidiary - - Foundation Health PsychCare Services, dba Occupational Health Services. The merged entity retained the name, Managed Health Network (MHN) and is the behavioral health subsidiary of Health Net, Inc.

### **Survey Results**

As part of the Focused Survey, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act: **Access and Availability of Services, Utilization Management/Benefit Coverage, Continuity and Coordination of Care, and Delegation Management.**

The Department identified five deficiencies in the Plan's implementation of and compliance with Section 1374.72 (see Section III, Table 1). The Plan has implemented corrective actions for these deficiencies. Based on its review of the documents submitted by the Plan in its response, the Department has determined that the Plan has corrected one of these deficiencies. One deficiency in the area of Access and Availability, two deficiencies in the areas of Utilization Management/Benefit Coverage, and one deficiency in the area of Continuity and Coordination of Care remain uncorrected at the time of this Final Report.

Please refer to Section III for a detailed discussion of the deficiencies, the Departments findings, required corrective actions, the Plan's response and compliance efforts, and the Department's final determination regarding the status of the deficiencies.

## **SECTION I. FOCUSED SURVEY BACKGROUND**

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The Department's authority to conduct surveys comes from Knox-Keene, which mandates that the Division of Plan Surveys ("Plan Surveys") conduct onsite medical surveys of all licensed health plans at least once every three (3) years, including full-service and specialized plans. Full-service health plans are defined as plans that provide all basic health care services. Specialized plans include behavioral health, vision, dental, and chiropractic plans.

In its planning for 2005, the Department's administration directed Plan Surveys to design focused surveys to review health plan compliance with enacted mental health parity laws. The project began in November 2004 and includes three phases:

- (1) Stakeholder input, inclusive of several meetings held to gather comments and identify issues currently voiced in the mental health community;
- (2) Operations component, included survey tool development and scheduling; and
- (3) Conduct the surveys.

The Department supports continued discussions with stakeholders and will receive comments and suggestions throughout the project.

The purpose behind the focused surveys was to assess specific plan compliance and also to research some of the problems voiced by stakeholders, such as inadequate access to mental health providers and lack of payment of emergency mental health services. Meeting the challenges of implementation of the parity law from the health plan perspective was addressed with Plan management during the first day of the focused survey.

### **The Focused Survey Approach**

Focused surveys give the Department the ability to swiftly respond to potential serious health plan problems, concerns, or questions raised by consumers, legislators or other Department divisions on a particular issue. Focused surveys could include an assessment of compliance with newly enacted legislation, such as the Parity Act or specific applications such as Diabetes supplies regulations.

Although Section 1374.72 is reviewed by the Department for compliance as part of the normal routine medical survey process, this focused survey approach allows a more detailed look at application and compliance.

## SECTION II. SCOPE OF WORK

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The subject of this Focused Survey is Health and Safety Code Section 1374.72, Rule 1300.74.72, and other relevant sections of Knox-Keene, including but not limited to:

- Determining whether the plan and its contracted mental health plan have developed and maintained adequate provider networks to promote timely access to mental health services;
- Determining whether the plan and its contracted mental health plan are effectively coordinating the care of enrollees and providing continuity of care; and
- Determining whether the plan and its contracted mental health plans are authorizing and providing medically necessary services mandated under Section 1374.72 in an appropriate and timely manner.

Specifically, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act:

- **Access and Availability of Services** – to determine whether the Plan designs benefits for parity diagnoses under the same terms and conditions applied to other medical conditions, whether the Plan clearly communicates those terms and conditions to enrollees, and whether the Plan has developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services.
- **Continuity and Coordination of Care** – to determine whether the Plan provides appropriate continuity and coordination of care for enrollees with parity diagnoses.
- **Utilization Management/Benefit Coverage** – to determine whether the Plan appropriately authorizes and provides medically necessary treatment and services required under Section 1374.72 to enrollees with parity diagnoses.
- **Delegation Management** - when applicable, to determine whether the Plan adequately and appropriately oversees its contracted specialty mental health plan and ensures that parity mental health services are provided to enrollees with parity conditions in a timely and appropriate fashion, under the same terms and conditions applied to medical conditions.

## SECTION III. SURVEY FINDINGS

The table below lists deficiencies identified during the Focused Survey. The Department issued a Preliminary Report to the Plan regarding these deficiencies on June 23, 2005. In the Report, the Plan was instructed to: (a) develop and implement a corrective action plan (CAP) for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

**TABLE 1: DEFICIENCIES**

#	SUMMARY OF DEFICIENCIES	STATUS
<b>A. ACCESS AND AVAILABILITY OF SERVICES</b>		
1	<b>The Plan does not clearly present the differences between the benefits available for parity mental health conditions and the benefits available for non-parity mental health conditions to enrollees who contact the Plan to obtain benefit information or to access services.</b> [Rule 1300.67.2(g)]	Corrected
2	<b>The Plan does not adequately ensure that the provision of after-hour services is reasonable.</b> [Rule 1300.67.2(b) and Rule 1300.74.72(f)]	Not Corrected
<b>B. UTILIZATION MANAGEMENT/BENEFIT COVERAGE</b>		
3	<b>Benefit termination letters for Healthy Families enrollees do not clearly explain the reason for termination of services for children who are potentially seriously emotionally disturbed and the process by which the Plan refers these children to county mental health systems for SED evaluation.</b> [Section 1367.01(h)(4)]	Not Corrected  <b>Remedial Action Required</b>
4	<b>The Plan incorrectly and inappropriately denies payment for emergency claims.</b> [Section 1371.4(b)(c)]	Not Corrected
<b>C. CONTINUITY AND COORDINATION OF CARE</b>		
5	<b>The Plan does not monitor and improve the exchange of information between and among medical and mental health providers in a systematic and comprehensive manner.</b> [Rule 1300.74.72(g)(3)]	Not Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

## A. ACCESS AND AVAILABILITY OF SERVICES

**Deficiency 1:** The Plan does not clearly present the differences between the benefits available for parity mental health conditions and the benefits available for non-parity mental health conditions to enrollees who contact the Plan to obtain benefit information or to access services. [Rule 1300.67.2(g)]

### Documents Reviewed:

- Policy: Administration of the California Parity Benefit, Draft Version, effective 4/25/05
- MHN Job Description: Intake Specialist

**Department Findings:** Enrollees must call the Delegate at the telephone number listed on their member identification cards and speak to an intake specialist to verify eligibility, obtain mental health benefit information, obtain referrals, and receive preauthorization for services. For callers who appear to be emotionally stable and in minimal distress and who appear to have uncomplicated treatment needs, the intake specialist may provide information and make referrals for outpatient mental health services based on the member's stated needs and requests. The member is transferred to a licensed care manager only if the member has more complicated needs, presents as emotionally distressed, or gives other evidence of a serious mental illness.

The Department reviewed the Delegate's policies and procedures and other documents related to the orientation and training of intake specialists, and discussed the intake process with the Delegate's Vice President for Quality Improvement. The Department also interviewed an intake supervisor regarding the specific manner in which intake specialists are trained to present benefit information to members. The Delegate's procedures call for intake specialists to quote only non-parity benefits to members who call with ostensibly uncomplicated needs. Typically, care managers describe parity benefits to members only if and when a parity-related condition is indicated that may be the focus of treatment.

Among the documents the Department reviewed was a draft policy and procedure dated April 25, 2005 and titled "Administration of the California Parity Benefit." The policy did not include a date for committee review and approval, and appeared to be still in development when the Department reviewed it. The policy states that intake specialists present both parity and non-parity benefits clearly when they speak with "...members for whom parity benefits may apply." As reported by the Vice President for Quality Improvement, the Delegate has recently recognized that it does not provide full information to enrollees and has already initiated efforts to achieve compliance.

**Implications:** A system that bifurcates handling of enrollees between intake specialists and care managers and where only care managers discuss benefits afforded to individuals with parity diagnosis raises concerns as to adequacy to ensure comprehensive benefit information is provided to all eligible enrollees. Behavioral health treatment compliance is inherently problematic. To the extent that a person needing mental health treatment perceives his/her benefit to be limited, that person may avoid or delay treatment in order to avoid exhausting the benefit and incurring out-of-pocket expense. The failure to receive appropriate, timely treatment

may place an individual at risk for decompensation, unnecessary morbidity, and adverse treatment outcomes.

**Corrective Action:** The Plan shall provide evidence that its Delegate has revised the policy titled “Administration of the California Parity Benefit,” including any and all related policies, to require that intake specialists and care managers describe both parity and non-parity benefits clearly and accurately to all members who receive benefit information and authorization for services.

The information should be presented in a manner that educates the member regarding the availability of parity benefits when responding to callers inquiring about mental health services and benefits. For parents of Healthy Families enrollees, the intake specialist or care manager shall explain that extended mental health benefits are available for seriously emotionally disturbed (SED) children through referral to county mental health programs.

Further, the Plan shall provide evidence that the Delegate has retrained its intake and care management staff to present parity versus non-parity mental health benefit information correctly to all members who receive benefit information.

**Plan’s Compliance Effort:** The Plan stated that the Delegate has updated the policy entitled, “Administration of the California Parity Benefit.” The revised policy and procedure requires that intake specialists and care managers describe both non-parity and parity benefits clearly and accurately to all members (and member representatives) at times when benefit information or authorization is being requested. On July 11, 2005 training was conducted for all current staff regarding these updates. The training department has also integrated the new scripts and procedures into the training of new employees.

The Plan also stated that as of May 10, 2005 specialized scripts have been developed and distributed to intake specialists in order to assist them during calls with Plan members, including Healthy Families members. The system has been set up to automatically alert intake specialists to quote parity benefits for Plan members, including Healthy Families members.

Finally, the Plan stated that in order to monitor the Delegate’s compliance with the new requirement the new procedure has been added to the internal auditing tool used by all supervisors monitoring the content and quality of their intake specialists’ calls. Since implementation, the internal auditing of intake specialists’ according to the revised policy demonstrates 92% compliance with quoting parity benefits during benefit inquiries and authorization requests. For the month of June 25 audits were reviewed. A total of 23 passed with procedural accuracy according to the audit tool’s requirement to clearly and accurately quote parity benefits to all members seeking benefit information or authorization. Should an intake specialist, after the new employee probation period, fail to pass five audits in a given month, more aggressive training and auditing is initiated for that intake specialist.

**The Plan submitted the following documents:**

- Copy of policy titled “Administration of California Parity Benefit”
- Template scripts to quote benefits and Script for Quoting Parity/SED Benefits
- An example System Alert which helps staff determine whether to read Parity Script to caller
- An example System Alert which helps staff understand the Healthy Families benefit structure as it pertains to SED and Parity
- A copy of an intake specialist audit tool

**Department’s Finding Concerning Plan’s Compliance Effort:**

**STATUS: CORRECTED**

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has appropriately revised its policy, developed materials to assist staff in providing the appropriate information and retrained staff. The Plan has also instituted an internal auditing system to monitor consistent application of its revised policy.

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**Deficiency 2: The Plan does not adequately ensure that the provision of after-hour services is reasonable. [Rule 1300.67.2(b) and Rule 1300.74.72(f)]**

**Documents Reviewed:**

- MHN Policy and Procedure: Monitoring Access to Care
- MHN Online Provider Manual
- MHN Participating Provider Agreement
- MHN Initial Credentialing and Demographic Application
- Survey of 52 MHN Providers, conducted from May 9, 2003, through May 11, 2005

**Department Findings:** The Plan’s Delegate provides access to intake specialists and clinical personnel 24-hours a day / 365 days a year through a 24-hour toll-free telephone service. By means of this telephone service, the Delegate provides enrollees with referrals for appointments, initial authorizations for services, crisis intervention, responses to questions about coverage and benefits, and if necessary, arrangements for emergency care or hospitalization. While the Plan makes in-bound call center services available 24-hours a day through the Delegate, it does not ensure continuous availability of its providers should an enrollee attempt to contact his/her provider directly in a crisis.

Not only is after-hours coverage necessary, but also because many mental health practitioners operate in solo practices, they are often not available to answer the phone even during normal business hours (e.g., during counseling sessions). An enrollee desiring to contact a provider (either for an initial appointment or as a continuing patient) will, therefore, often reach the same answering machine message or answering service that the provider uses for after-hours coverage. Both during and after business hours, the Plan must ensure that providers have made reasonable

provisions for service.

The Delegate's Provider Manual states: "Practitioners shall be available and accessible to members during reasonable hours of operation, with provision for after-hours services, if applicable." In the Participating Provider Agreement, the Delegate specifies that: "Covered Services shall be available and accessible to Enrollees during reasonable hours of operation, with provision for after-hours services, if applicable. Emergency Care shall be available and accessible 24-hours a day, 7 days a week." On its Initial Credentialing and Demographic Application, the Delegate advises the following: "In addition, practitioners must be available for emergency appointments." Although the Delegate requires "reasonable" coverage during and after business hours, it has not established clear criteria for acceptable arrangements and/or message content to guide its providers in establishing their systems and to guide its own evaluation of those systems. Additionally, the Plan does not have a formal means of monitoring whether providers have appropriate answering machine messages and respond to enrollee messages in a timely fashion.

The Department surveyed 42 providers by telephone during normal business hours to assess provider responsiveness, appointment availability and whether the practice was open to new patients (see Table 2). If the provider or provider staff did not answer the call, the Department assessed:

- Whether an answering machine message or service was in place;
- Whether the answer machine message contained a pager number or other instructions by which the enrollee could reach the provider; and
- Whether instructions guided callers to contact 911 or to follow other instructions in the event of an emergency.

The Department also left a message requesting a return call and monitored whether a return call was received within the Delegate's own standard of two business days. The Department found that four of the calls were answered by a "live person," either the provider or office staff. The other 38 providers had automated answering systems in place. Of these, 26 contained emergency instructions either to contact 911 or to pursue some other source of emergency assistance, including provider pager numbers, local crisis response teams, and/or dialing another specified number for help. However, these messages were inconsistent, and 12 practitioners gave no emergency instructions at all.

**TABLE 2: TELEPHONE SURVEY OF PROVIDERS**

TOTAL CALLS					If Not Answered By Provider/Staff				If Contact With Provider Or Office Staff	
Type of call	Answered by provider or office staff	Not answered by provider or office staff	Message left. Call back within 2 business days	Total Contacts with provider or office Staff	Answering machine (M) or answering service (S)	If Answering Machine:			Open to new patients	Meets Plan's routine appointment availability standard of 10 working days
						Machine directed enrollee to 911	Additional emergency instructions (e.g., pager, crisis line, crisis center)	Total with 911 and/or other emergency instructions		
Calls during business hours	4 (10%) N=42	38 (90%) N=42	19 (59%) N=31*	23 (55%) N= 42	M=38 S=0 N=38	13 (34%) N=38	20 (53%) N=38	26 (68%) N=38	20 (80%) N=25**	19 (95%) N=20
Calls after hours	0 (0%) N=10	10 (100%) N=10	N/A	N/A	M=9 S=1 N=10	3 (33%) N=9	8 (89%) N=9	9 (100%) N=9	N/A	N/A

\* Message not left for provider for following reasons: outgoing message states new patients are not being accepted (4); outgoing message states provider on vacation beyond end of survey (1); voice mail system would not take a message (2).

\*\*Includes two providers whose answering machine message said that they were not taking new patients in addition to the 23 providers with which the surveyor had contact.

Messages were left for 31 of the 38 providers that could not be contacted directly. Messages were not left for seven providers, either because the provider was on vacation, or the answering system did not allow messages or the provider stated in his/her message that s/he was not accepting new patients. Of the 31 providers for whom messages were left, 19 responded with a return call within the Delegate's standard of two business days; the remainder did not.

The Department also performed a telephone survey of ten providers after normal business hours to assess the presence and content of answering service/machine messages. One of the calls was answered by a live answering service; machines answered the remaining nine. Of these, all nine provided some type of emergency instruction.

**Implications:** Although an enrollee may initially contact the Delegate through its 24-hour line to arrange for services and may contact the Delegate at any time to arrange for emergency care, once an enrollee has established a therapeutic relationship with a provider, that enrollee may attempt to contact the provider prior to or instead of contacting the Delegate in an emergency or urgent situation. For this reason, access to individual providers both during and after business hours must be ensured, and/or clear instructions provided via provider messaging systems regarding how patients may contact the provider and/or other sources of assistance. Although some providers report utilizing call forwarding or frequent monitoring of their answering systems, this information and emergency instructions should be clearly indicated in outgoing messages so members can be assured their provider will receive the message. Additionally, the Plan must ensure that providers respond in a timely manner to messages left for providers in

order to facilitate prompt handling of current patients' needs, and to respond expeditiously to calls for new appointments.

**Corrective Actions:** The Plan shall provide evidence that its Delegate has developed standards by which to monitor after-hours availability of its providers and distributed to its providers clear and detailed instructions regarding its requirements for messaging and after-hours telephone coverage.

The Plan shall also provide evidence that the Delegate has established a system for monitoring provider after-hours arrangements, including the presence and content of provider answering system messages and the timeliness of providers' responses to messages left by enrollees.

**Plan's Compliance Effort:** The Plan stated that its Delegate has amended the "Participating Provider Agreement" to require that providers make reasonable provision for services during and after hours. Under Section 2.2 of the "Participating Provider Agreement -- Accessibility of Covered Services," the language was amended to require that providers include instructions as to what to do in case of an emergency when a person does not pick up the call or the inquiry is sent via email. Additionally, language was added requiring providers to return calls within two business days. The Delegate will contract all new practitioners under the revised "Participating Provider Agreement".

The Delegate has sent a notice of this requirement to all contracted providers in California. This notice provides clear examples for emergency instructions and confirms the requirement to return Plan member calls within two business days. This mailing was sent to providers on August 5, 2005. The Delegate will place a reminder in the 3<sup>rd</sup> Quarter Provider Newsletter (Aug. '05). The reminder will give examples of appropriate after-hour voice mail instructions and emphasize the need to return calls to the Plan members in two business days.

The Delegate currently conducts a quarterly telephone demographic audit on a subset of the contracted network. The Plan stated that it would add to the audit process adherence to the emergency instructions referenced above. Providers found not to be in compliance as part of the audit will be contacted, educated, and re-audited.

The Plan also stated that the Delegate would monitor adherence to the two-day call back requirement through the complaint databases maintained by Quality Management and Professional Relations. By the end of the third quarter 2005, the Delegate's Professional Relations and Quality Management Departments will initiate quarterly cross-references of the complaint databases maintained by both departments. Provider access and availability are in the scope of this process. If an inappropriate pattern is found with a Provider, the VP of Professional Relations and/or the VP of Quality Management or their designee will determine the action to be taken. Such action may include, but is not limited to, placing the Provider on a CAP or presentation to the Delegate's Credentialing Committee for action, up to and including termination.

**The Plan submitted the following documents:**

- A sample of the new contract language
- A copy of the notice providing examples for emergency instructions
- A copy of the draft reminder article

**Department's Finding Concerning Plan's Compliance Effort:**

**STATUS: NOT CORRECTED**

The Department finds that this deficiency has not been fully corrected.

The Plan has communicated the information regarding after-hours requirements to its providers via contract modifications and a mailing. The Plan has also proposed acceptable approaches for monitoring both after-hours arrangements and provider responsiveness to enrollee messages.

The Plan was unable, however within the 45-day response period, to fully implement its proposed monitoring systems and demonstrate the effectiveness of its corrective actions. At the time of the next scheduled Follow-Up Review for the current Routine Medical Survey cycle, the Department will review the implementation and results of the Plan's monitoring. The Follow-Up is projected to take place no later than July 2006.

**B. UTILIZATION MANAGEMENT**

**Deficiency 3: Benefit termination letters for Healthy Families enrollees do not clearly explain the reason for termination of services for children who are potentially seriously emotionally disturbed and the process by which the Plan refers these children to county mental health systems for SED evaluation.** [Section 1367.01(h)(4)]

**Documents Reviewed:**

- 40 benefit denial files from March 2004 through February 2005, of which 13 benefit denial files were for children with Healthy Family coverage.

**Department Findings:** As shown in Table 3 below, in 13 benefit denial letters, the Delegate did not clearly explain the reason for the benefit denial, consistent with the provisions of the enrollee's Evidence of Coverage. All 13 benefit denials were for children with Healthy Families coverage whom the Delegate had identified as being potentially SED. In these benefit denial letters the Plan stated: "The member has utilized his/her annual dollar or session/day maximum benefit for this services....As an alternative to the mental health or substance abuse services requested, please consider referral to the county Mental Health department in county of residence and assume financial responsibility for ongoing services."

The letter template contains several deficiencies: **1)** It incorrectly states that the Healthy Families enrollee has exhausted benefits, when, in fact, the Plan uses this letter principally to notify the parents of the child that the child may be SED and eligible to receive services beyond the benefit limit through the county mental health services programs. Plan staff stated that this is usually done prior to the child exhausting his/her benefits to allow time for the evaluation. **2)** The letter

neither clearly explains the Healthy Families contractual requirement for this referral nor describes the Delegate's process to request that the county mental health services agency evaluate the child and how the child's care will be transferred to the county, if applicable. 3) The letter inaccurately implies that it is the responsibility of the parent, rather than the Plan, to request that the county mental health services agency evaluate the child.

These results were reviewed with Delegate staff, who indicated that staff members were already in the process of changing the denial letters to notification letters that explain that the child appears to be eligible for extended mental health benefits through the county mental health system as an SED child and that the Delegate has notified the county to contact the family to arrange for an evaluation.

**TABLE 3: BENEFIT DENIALS**

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Benefit Denials	40	The reason for the benefit denial accurately reflects the provisions of the relevant Evidence of Coverage.	27	13

**Implications:** Families of seriously emotionally disturbed children may not understand that, under their Healthy Families contracts, their children are eligible to receive services through county mental health services, and may, therefore, not follow up on the referral to county medical services. Parents may also be unnecessarily concerned that they will be burdened with the cost for any further treatment of their child that may be available through the county mental health system.

**Corrective Action:** The Plan shall submit evidence that the Delegate has revised its Healthy Families notification letter to provide a clear explanation of why the Delegate has requested that the county mental health system evaluate the child to determine whether the child is seriously emotionally disturbed and eligible for services through the county mental health system. The Plan shall also provide evidence that the Delegate is using the new letter template.

**Plan's Compliance Effort:** The Plan stated that its Delegate has changed the Policy and Procedure regarding notification of evaluation and transition to the county mental health system (the "county") for Healthy Families members eligible for extended mental health benefits as follows:

- 1) When a member or member representative (provider, facility or family member) calls to request services, care managers must determine, using the Seriously Emotionally Disturbed Decision if it is appropriate for the member to be evaluated by the county.
- 2) Upon a determination that a member qualifies for an evaluation, the care manager refers the member to the county and sends a notification letter to the member.
- 3) If the county determines that the member is SED, the county notifies the Delegate and the Delegate sends a second notification letter confirming the transition to the member.

These decisions are no longer handled as denials, and accordingly, since the Focused Review, there have been zero benefit denials for the reason of transitioning to county services. Since implementation, several notification letters have been issued to members and their families. The Plan's review of these cases confirmed use of the correct letter templates, as discussed above.

In addition, the Plan stated that the Delegate uses a log to track the referrals to the county for evaluation, the responses, and the care received by Healthy Families members. The Plan and the Delegate can then track whether a particular member was referred to or accepted by a county. At the end of each quarter, the Delegate sends the information to a senior public health program administrator at the Plan in order to facilitate the submission of this and other data to the Managed Risk Medical Insurance Board.

**The Plan submitted the following documents:**

- A copy of the Seriously Emotionally Disturbed Decision Tree
- Sample of member notification letter
- Sample of second notification letter

**Department's Finding Concerning Plan's Compliance Effort:**

**STATUS: NOT CORRECTED**

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has implemented changes in its policy and procedures to improve referral of enrollees for evaluation by the county. The Department finds, however, that the new template notification letters remain unclear and can be misleading to enrollees. The notification letters state that, because the child has been assessed by the county and determined to be Seriously Emotionally Disturbed, "the county is therefore responsible for your child's ongoing mental health care." The county mental health system is not solely responsible for ongoing care of children with SED. The Plan is required to provide services according to the benefit plan stipulated by Healthy Families. Referral to the county and determination that the member meets the criteria for SED do not necessarily mean the Plan is free of its responsibility to cover services stated in the benefit plan (e.g., 20 outpatient visits and 30 inpatient days per year.) The letters do not explain that care is available from the Plan until benefits are exhausted, which may lead enrollees/parents to believe that care from that point forward must be obtained from the county.

**Remedial Action Required:** The Plan shall revise its notification letters to more fully and clearly explain the circumstances under which the county has responsibility for providing services. The Plan shall submit a copy of the corrected template letters to the Department within 30 days of the date of this report.

Once the review is complete, the Department will inform the Plan of any further action to be taken to fully correct this deficiency. In addition, at the time of the next scheduled Follow-Up Review for the current Routine Medical Survey cycle, the Department will review the

implementation and results of the Plan's monitoring. The Follow-Up is projected to take place no later than July 2006.

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**Deficiency 4: The Plan incorrectly and inappropriately denies payment for emergency claims.** [Section 1371.4 (b) and (c)]

**Documents Reviewed:**

- 37 emergency service claims from October 2004 through March 2005

**Department Findings:** The Department reviewed a total of 37 claims for emergency services (ER). Eleven were disqualified from the final findings because they were denied for administrative reasons (e.g., not eligible). A net total of 26 ER claims were reviewed: 18 from non-participating providers; and eight from participating providers. Five of the 26 claims were from county facilities. The Department found that the Plan inappropriately denied 25 of the 26 of the ER claims.

The Department's findings are summarized in Table 4.

**TABLE 4: EMERGENCY ROOM CLAIM DENIALS**

File Type	Number Of Files Reviewed	Criteria	Number Compliant	Number Deficient
Par ER Claims	8	Appropriate Denial	1	7
Non-Par ER Claims	18	Appropriate Denial	0	18
• County Facilities	5	Appropriate Denial	0	5
Total	26		1	25

The Delegate uses the prudent layperson rule when processing ER claims. Claims for emergency services related to behavioral health or substance abuse do not require preauthorization.

The claims examiner uses the following guidelines in processing emergency claims:

- The Delegate is responsible for medically necessary inpatient and outpatient services rendered by a mental health professional for mental health and/or substance abuse diagnoses. Several diagnosis codes are excluded from Delegate's liability (and are the Plan's responsibility). None of these diagnoses is a mental health parity diagnosis.
- All ER claims from participating providers are paid at 100% of billed charges.
- All ER claims from non-participating providers that are less than \$1500.00 are paid at 100% of billed charges.

- All ER claims from non-participating providers that are more than \$1500.00 are sent for medical review for determination of medical necessity.
- If an ER claim does not contain complete medical records, the examiner requests for medical records and pends the claim until information is complete.
- Certain emergency claims may be paid automatically according to the diagnosis and CPT and other revenue codes without the benefit of a medical review. A listing of diagnoses and revenue codes that may be paid automatically is used as reference by the examiner.
- If an ER claim contains “mixed” (contains both mental health and medical services) service components, the Delegate pays for the mental health benefits and denies the rest of the claim as “not covered benefit.”

The Department found that the Delegate’s examiners do not consistently follow its claims processing guidelines. For example:

- While the Delegate states that it does not require preauthorization for emergency claims, 11 of the 26 claims reviewed were denied for lack of authorization.
- While the Delegate states that claims above \$1500.00 are sent for clinical review, not all of these claims were sent to clinical review.

The Department also found that the Delegate denied claims sent for clinical review because the results of the review were unavailable. Rather than have the claim fall out of the required timeframe of 45 days, the examiners stated that they deny the claim and cite “lack of authorization” as the reason for the denial. When the Department asked the Delegate if this was part of the processing guidelines, they conceded that it was a common practice but not part of the claims protocol. They stated that corrective actions have been immediately instituted following discovery of this practice.

Six of the 25 inappropriately denied claims were reprocessed for payment prior to the Department’s review due to one of the following reasons: enrollee inquiry, internal audit or provider dispute. Eleven claims were reprocessed for payment and three were forwarded for clinical review shortly after the claims were selected for this Focused Parity Survey.

Five county facility claims were inappropriately denied initially:

- Two were denied due to lack of authorization but subsequently paid. It is not known if a provider dispute or member appeal triggered the reprocessing.
- One claim denied as “not a covered service” was subsequently paid shortly after its selection for review during this Focused Survey.
- One claim paid to the wrong provider was resubmitted and denied as a duplicate.
- One claim inappropriately pended for lack of medical information had the information requested attached to the claim upon initial submission. The claim was subsequently paid shortly after its selection for review during this Focused Survey.

The Delegate staff conceded that they are not appropriately following their own guidelines and their processes are flawed. Plan officers assured the Department that changes to improve their processes are underway.

**Implications:** Incorrect denial of payment for health care services to which enrollees are entitled breaches the agreement between the enrollee and the Plan for covered services, may create a barrier to future services based on previously denied payments, and may result in providers inappropriately billing enrollees for these services.

**Corrective Action:** The Plan needs to provide oversight and monitor to criteria such that ER claims are appropriately paid. The Plan shall develop and implement an internal audit program designed to monitor compliance with its ER claims processing policies and procedures.

Suggested audit criteria may include, but not be limited to:

- Total number and percent of ER claims that qualified for automatic payment;
- Total number and percent of ER claims that qualified for and were automatically paid;
- Total number and percent of ER claims that were referred for medical review; and
- Accuracy of medical review determination, based on statutory requirements.

It is recommended that files selected for audit include appealed cases as well as initial determinations.

The file sampling method should be proportional to the total number of facility types (participating, county, other) from which the Plan receives ER claims. For example, if claims from county facilities account for 20% of the Plan's total ER claims, then 20% of the ER claims selected for audit should be from county facilities.

The Plan shall establish an implementation date for the audit program no later than two months from the date of this Preliminary Report, and shall include the implementation date in its response to this Preliminary Report. Audit results shall be reported to the Department within a reasonable timeframe, after three and six months of the implementation date.

**Plan's Compliance Effort:** The Plan stated that its Delegate has revised its claims policy and procedure regarding payment of ER claims. The revised policy became effective May 11, 2005. The revised policy directs the examiner to pay all Emergency Room claims, regardless of authorization status and amount billed, if the member is an eligible plan member. A special training session was held with claim staff to alert them to the policy change.

The Plan also stated that its Delegate immediately implemented a focused audit of ER facility claims processed June 1, 2005, and after. The audit program consists of a review of 100% of ER facility claims that have been denied for any reason other than a duplicate claim or member not eligible. Audit results will be reported to the Department and will reflect activity for the subsequent three months and six months following the start of the audit program. The first report will be sent to the Department by September 15, 2005. The report will show all ER claim

activity, number of claims paid, number of claims denied and claims sent for medical review for the first three months (June, July, August) following implementation of the audit program on June 1, 2005. The second report will be sent on December 30, 2005 and will show activity and audit results for September, October and November 2005. The Delegate will query the dispute and appeals departments regarding any appeals and/or disputes that are received due to non-payment of an ER claim for behavioral health services covered by the Plan to assure all possible issues in claim payment are addressed. The audit program will continue until at least 95% compliance in claim payment is achieved consistently for at least six months.

The Plan submitted the following document:

- A copy of the revised policy regarding ER payments

### **Department's Finding Concerning Plan's Compliance Effort:**

#### **STATUS: NOT CORRECTED**

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has revised its claims policy and instituted internal auditing procedures to address this issue. The Plan has not, however, had sufficient time within the 45-day response period to provide audit results to demonstrate the effectiveness of the Plan's corrective actions.

The Plan's first audit results, which were forwarded to the Department on November 9th, along with the results of the second audit due by December 31, 2005, will be reviewed. Once the review is complete, the Department will inform the Plan of any further action to be taken to fully correct this deficiency.

## **C. CONTINUITY AND COORDINATION OF CARE**

**Deficiency 5: The Plan does not monitor and improve the exchange of information between and among medical and mental health providers in a systematic and comprehensive manner. [Rule 1300.74.72(g)(3)]**

### **Documents Reviewed:**

- MHN Job Description: Clinical Operations Care Manager Position Description
- Targeted Intensive Care Management Program (TICM)
- MHN Process for Screening for and Co-Management of Coexisting Medical and Mental Health Conditions Policy
- MHN AS 400 Case Document
- Monthly Co-Management Meeting Agenda
- 17 active care management files

**Department Findings:** Neither the Plan nor the Delegate, separately or together, has a comprehensive process that assures continuity and coordination of medical and mental health for all enrollees, including those with parity diagnoses.

The Delegate has two levels of care management for timely communication between and among enrollees' mental health providers and between enrollees' medical and mental health providers. The first level is essentially utilization management and consists of the care manager performing the following activities:

- Assessing the patient for medical necessity;
- Authorizing treatment according to MHN's criteria;
- Documenting all initial and concurrent review;
- Closing all cases according to defined case closure procedure in a timely manner;
- Consulting with providers as needed;
- Performing provider recruiting duties when there is a need for *ad hoc* contracting;
- Serving as a liaison to other departments; and
- Participating in training.

When a care manager at either the Plan or the Delegate identifies an enrollee that requires co-management, the care manager contacts a counterpart care manager to coordinate the enrollee's care. Medical Directors from the Plan or the Delegate also contact each other directly for assistance on specific cases.

No other documentation was provided that describes or demonstrates a clear, objective process that assures coordination of medical and mental health care. When the Department reviewed the first level of care management with the Delegate, staff acknowledged that this level consists primarily of utilization review of episodes of care and does not include ongoing management of the enrollee's condition. Thus, no outpatient care management is provided for an enrollee discharged from the hospital unless the enrollee meets the eligibility requirement for the TICM Program.

The TICM program targets individual cases based on predefined selection criteria. To qualify for the program, the enrollee must have had at least three admissions to higher levels of care during the preceding year and have one of 14 specific conditions or have any three of the 14 specified conditions. Because of the restrictive admission criteria specifications, the program has only 17 enrollees. The Department reviewed the 17 enrollee cases and determined that the Delegate followed up and coordinated care to meet each enrollee's behavioral, social, and medical needs.

Although the Delegate provides intensive case management, neither the Plan nor the Delegate has structured protocols or processes for individuals not as severely impaired. For example, no defined processes ensure that enrollees who have autism receive speech therapy or occupational therapy, if needed, through community agencies such as regional centers, the school system, the health plan, or the enrollee's medical group. Similarly, no case management program is provided for individuals at risk for meeting the criteria for the TICM program as evidenced by having difficulty adhering to medical and/or mental health treatment

plans, having complicated psycho-social environmental issues, failing to seek outpatient care after an inpatient episode, etc. The Department is concerned that the Plan and Delegate may not be meeting the needs of subsets of the enrollee population who could benefit from less intensive care coordination.

**Implications:** Failure to ensure the exchange of information between and among medical and mental health providers can result in poor medical and mental health outcomes as a result of inappropriate prescribing of medications, failure to monitor the medical or mental health side-effects of medication, and failure to ensure that the enrollee receives preventive health services.

**Corrective Action:** The Plan shall provide evidence that, working with its Delegate, it has developed a system and mechanisms to ensure communication takes place and coordination of care is facilitated as appropriate between mental health and medical providers for enrollees.

**Plan's Compliance Effort:** The Plan stated that the Plan and its Delegate have identified several ongoing care coordination/co-management programs that are being separately tracked, and are currently working on an action plan for central reporting and oversight of these programs by the Plan/Delegate co-management committee, which meets monthly. These programs include:

- The Plan's Renaissance Program which screens End Stage Renal Disease patients for depression and refers them to the Delegate's Coordination of Care Unit for further depression screening, outreach, and intervention.
- The Plan's Geriatric Health Services Program, which conducts health risk assessment surveys for new Medicare members and refers them to the Delegate for further depression screening, outreach, and intervention.
- The Plan's Pain Management program wherein Plan and Delegate representatives meet monthly to discuss cases and coordinate regarding depression screening, referral and intervention.

The Plan also stated that it and the Delegate have developed a Co-Management Referral form by which non-urgent/emergent co-management requests can be processed between the Plan, including delegated medical groups, and the Delegate. The forms and process will be distributed by September 1, 2005 to the delegated medical groups through Provider Updates and Medical Program Managers education provided at Joint Operating Meetings. The referrals from this form will be logged into the current co-management log of cases referred telephonically that is being maintained by the Plan/Delegate. The new Case Management Referral Process includes discussion of the cases from that log. In addition, any new cases will be discussed at the Plan/Delegate monthly co-management meeting, with case management representation. The focus will be on cases with diagnoses of autism, eating disorder, and other parity diagnoses, with scheduled follow-up reports on such cases. The current Plan/Delegate co-management monthly meeting format will change effective August 30, 2005, to include the update, discussion, and review of all co-management programs processes and progress and any administrative issues or problems, as well as review of cases from the prior month's co-management log and any new care coordination cases. These cases will include specific identification of autism cases, eating disorder cases, and cases with other parity diagnoses and co-morbid medical issues. Minutes are being kept of all meetings that include discussion of all cases.

In addition, the Delegate is to participate in monthly Plan Grand Rounds presenting co-morbid psychiatric/medical cases, and the Delegate will participate on a quarterly basis in regular Plan case management staff meetings to discuss co-morbid psychiatric/medical cases and coordination processes.

**The Plan submitted the following documents:**

- A copy of the template form
- A copy of the Co-management with MHN Flowchart

**Department's Finding Concerning Plan's Compliance Effort:**

**STATUS: NOT CORRECTED**

The Department finds that this deficiency has not been fully corrected.

The Department finds that the Plan has developed appropriate approaches to addressing this deficiency; however, the Plan has not had sufficient time during the 45-day response period to fully implement all of the proposed corrective actions and to demonstrate the effectiveness of these actions.

At the time of the next scheduled Follow-Up Review for the Plan's current routine medical survey cycle, the Department will review the co-management log, minutes of the co-management monthly meetings and related materials to assess the effectiveness of the measures instituted to ensure adequate exchange of information between and among medical and mental health providers. The Follow-Up is projected to take place no later than July 2006.

**D. SURVEY CONCLUSION**

The Department has completed its Focused Survey of the Plan. The Department will continue to monitor the Plan's compliance with the provisions of the Parity Act through its Routine Medical Surveys, which are conducted at least once every three (3) years.

The Department will develop a Summary Report that aggregates and analyzes the Parity Focused Survey results of all plans surveyed by Fall 2005. The Summary Report will be available to the plans and to the public through the Department's Public File.

## A P P E N D I X A

### METHODOLOGY & PARAMETERS

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#### A. Review Methodology

The Department conducted a Focused Survey of the Plan from May 9, 2005, to May 12, 2005, at the Delegate's offices in San Rafael, California, to evaluate the Plan's compliance with Section 1374.72. The Department conducted the survey utilizing the clinical expertise of three licensed professionals, including a board-certified psychiatrist, a licensed clinical social worker, and a registered nurse.

Survey activities included the review of plan documents, enrollee case files, and claims. The Surveyors conducted interviews with officers and staff from the Plan and its Delegate. Surveyors also telephoned 52 participating providers to assess appointment availability and evaluate the providers' after-hours telephone messages in regard to the provision of emergency services. Each survey activity is described in greater detail below.

**Review of Plan documents** – The Department reviewed a number of additional materials to assess various aspects of Plan compliance, for example:

- Policies and procedures for all related activities
- Internal performance standards and performance reports
- Communications regarding benefits
  - Explanation of coverage
  - Explanation of benefits
- Materials demonstrating continuity and coordination of care
  - Reports on inpatient admissions, office visits, and other services provided
  - Clinical practice guidelines and protocols
  - Case management program descriptions and case files
- Reports on access and availability of services
  - Number and geographic distribution of clinicians, facilities, and programs
  - Appointment availability
  - Timeliness of answering the triage and referral telephones
- Reports demonstrating the Plan's oversight of any activities performed by its Delegate

**Review of enrollee case files:** Prior to the onsite visit, the Department requested logs for a number of Plan activities, e.g., utilization review, claims processing, case management, etc. From these, the Department selected samples of case files for a comprehensive review. Review focused on measures such as appropriateness of denials of services, timeliness of decision-making, and coordination of care, as well as the appropriate exchange of information among providers.

The review of utilization management files was performed with the participation of Plan staff. Table 5 below displays the categories of utilization management files reviewed and the sample sizes selected.

**TABLE 5: FILES REVIEWED**

CATEGORY OF FILE	SAMPLE SIZE
Utilization Management - Medical Necessity Denials for Children	20
Utilization Management - Medical Necessity Denials for Adults	20
Utilization Management - Benefit Denials for Children	20
Utilization Management - Benefit Denials for Adults	20
Utilization Management - Denials of Non-Formulary Pharmaceuticals	10
Continuity and Coordination of Care – Case Management Files	17

**Review of claims** – Prior to the onsite visit, the Department requested claims listings. From these, the Department selected samples of claims for comprehensive review. Review focused on measures such as the appropriateness of denial and the accuracy of payment based on mandated parity benefits. The review of claims files was performed with the participation of Plan staff. Table 6 below displays the categories of claims reviewed and the sample sizes selected.

**TABLE 6: CLAIMS FILES REVIEWED**

CATEGORY OF CLAIM	SAMPLE SIZE
Claims for emergency services from non-participating providers	18
Claims for emergency services from participating providers	8

**Interviews** – The Department interviewed staff from both the Plan and Delegate to augment the review of documents and obtain a comprehensive picture of Plan activities surrounding the implementation of Section 1374.72, as well as to discuss the specific files, claims, and documents the Department reviewed. The list of individual officers and staff members interviewed, along with their respective titles, may be found in Appendix C. The list of the Department’s survey team members who conducted the interviews may be found in Appendix D.

## **B. Utilization Management File Review Parameters**

The parameters assessed during the review of each file included (as appropriate to each sample type):

- Diagnoses
- Accuracy of case categorization (parity vs. non-parity)
- Decision rendered/action taken by plan (approval or denial)
- Adequacy of clinical information obtained to support decision-making
- Documentation of rationale supporting the decision rendered
- Accuracy of decision based upon statutory requirements, and
- Consistency between decision and communication sent to the affected practitioner/provider and member

## **C. Claims Review Parameters**

The parameters assessed during the review of claims included:

- Diagnoses
- Accuracy of claim categorization (parity vs. non-parity; participating vs. non-participating; and emergency vs. non-emergency)
- Adequacy of administrative and clinical information obtained to support denial decision-making
- Appropriateness of denial
- Documentation of referral to medical review prior to denial decision rendered
- Accuracy of documented denial reason based upon plan policies regarding claim processing
- Accuracy of payment based on mandated parity benefits, and
- Appropriateness and accuracy of communication sent to the affected practitioner/provider and enrollee

## A P P E N D I X B

### OVERVIEW OF PLAN OPERATIONS

#### A. Plan Profile

Tables 7 through 9 below summarize the information submitted to the Department by the Plan and its Delegate in response to the Pre-Survey Questionnaire:

**TABLE 7: PLAN PROFILE**

Type of Plan	Full Service Plan	
Specialized Health Care Service Plan(s) or Mental Health Plan(s) with which the Plan Contracts for Provision of 1374.72 Services, as of April 1, 2005	Knox-Keene Licensed Behavioral Health Plan	Enrollees
	Managed Health Network (MHN)	1,382,748 (97%)
	United Behavioral Health and the Holman Group	14,057 (1%)
	Health Management Center	11,273 (0.7%)
	PacifiCare Behavioral Health	7,381 (0.5%)
	United Behavioral Health	6,295 (0.4%)
	Value Options	1,564 (0.1%)
	The Holman Group	1,186 (0%)
	<b>Total</b>	<b>1,424,504</b>
Specialty IPAs/Medical Groups with which MHN Contracts for the Provision of 1374.72 Services, as of March 1, 2005	IPA/Medical Group	Enrollees
	BHA	82,689
	College Health IPA	435,152
	<b>Total</b>	<b>517,841</b>
Number of Enrollees Covered by Mental Health Parity, as of April 1, 2005	Product Lines	Enrollees
	Commercial HMO	1,011,685
	Commercial POS	316,378
	HMO Healthy Families	96,441
	<b>Total</b>	<b>1,424,504</b>

<b>Service Area(s)</b> (Counties, in full or in part)	Alameda	Marin	Sacramento	Santa Clara
	Contra Costa	Merced	San Bernardino	Santa Cruz
	El Dorado	Monterey	San Diego	Solano
	Fresno	Napa	San Francisco	Sonoma
	Kern	Nevada	San Joaquin	Stanislaus
	King	Orange	San Luis Obispo	Tulare
	Los Angeles	Placer	San Mateo	Ventura
	Madera	Riverside	Santa Barbara	Yolo

#### Plan Identification of Enrollees Eligible for Parity Services

**Adults:** Adults with parity diagnoses are identified through the diagnosis submitted on the claim form.

**Seriously Emotionally Disturbed Children:** Children with parity diagnoses are identified through the diagnosis submitted on the claim form. Potentially seriously emotionally disturbed (SED) children covered under commercial contracts are identified through the child's provider informing the Delegate that the child is SED when submitting a request for authorization. If this does not happen prior to the authorization of 75% of the child's non-parity outpatient or inpatient benefit, the system flags the care manager to evaluate the child. The care manager does this through a review of the information obtained while authorizing care against the SED criteria and/or by the care manager contacting the child's therapist to review the child's status against the SED criteria.

Under the Healthy Families contract, the Plan must refer potentially seriously disturbed children to their local county mental health departments for evaluation. If the county mental health department determines that the child is SED, the child subsequently receives all his outpatient mental health services and any inpatient mental health services in excess of 30 days per benefit year through the county mental health system. The Delegate has recently implemented a new system to identify and refer potentially SED children earlier in their course of treatment to assure sufficient time for county mental health systems to complete their evaluations prior to enrollees exhausting their benefits.

**TABLE 8: MENTAL HEALTH PROVIDER NETWORK**

<b>Practitioners Who Treat Adults</b>	<b>Number in the Network</b>
Psychiatrists	8,602
Doctoral-level psychologists	2,258
Mental health nurse practitioners with furnishing numbers	9
Marriage and Family Therapists (MFT)	2,379
Licensed Clinical Social Workers (LCSW)	1,320
Other:	821
<b>Total</b>	<b>15,389</b>
<b>Practitioners Who Treat Children and Adolescents</b>	<b>Number in the Network</b>
Psychiatrists	474
Doctoral-level psychologists	1,782
Mental health nurse practitioners with furnishing numbers	6
MFTs	2,048
LCSWs	1,098
Other:	683
<b>Total</b>	<b>6,091</b>
<b>Institutional Providers and Programs That Treat Adults</b>	<b>Number in the Network</b>
Acute inpatient units—voluntary admissions	121
Acute inpatient units—involuntary admissions	71
Crisis treatment centers/programs	78
Intensive outpatient treatment programs/partial hospitalization	187
Residential treatment programs	58
Eating disorder programs	25

<b>Institutional Providers and Programs That Treat Children and Adolescents</b>	<b>Number in the Network</b>
Acute inpatient units—voluntary admissions	35
Acute inpatient units—involuntary admissions	28
Crisis treatment centers/programs	27
Intensive outpatient treatment programs/partial hospitalization	77
Residential treatment programs	21
Eating disorder programs	17

**TABLE 9: ACCESS AND AVAILABILITY STANDARDS**

Type of Practitioner	Ratio of Practitioners to Enrollees	Geographic Availability	Percent of Open Practices
Psychiatrists	1:5000 enrollees	95% of enrollees are within 30 miles of one practitioner	No standard
Doctoral-level psychologists	1:2300 enrollees	95% of enrollees are within 30 miles of one practitioner	
Master’s-prepared therapists	1:1150 enrollees	95% of enrollees are within 30 miles of one practitioner	
Appointment Availability Standards			
Type of Services		Standard	
Non-life-threatening Emergency		Within 6 hours	
Urgent Care		48 hours	
Initial Post-hospitalization Follow-up Visit		7 calendar days	
Routine Visit		10 business days	
Telephone Responsiveness Standards			
Telephone Availability		Standard	
Triage and Referral Speed of Answer		Not to exceed 30 seconds	
Triage and Referral Abandonment Rate		Not to exceed 5%	
Member Services Speed of Answer		Not to exceed 30 seconds	
Member Services Abandonment Rate		Not to exceed 5%	

## B. Overview of Programs

Table 10 below presents a brief overview of the Plan's operations in each of the four (4) program areas examined during the Department's focused survey.

**TABLE 10: OVERVIEW OF PROGRAMS**

PROGRAM	DESCRIPTION
<b>ACCESS AND AVAILABILITY</b>	<ul style="list-style-type: none"> <li>The Plan's Combined Evidence of Coverage and Disclosure Form and the Summary of Benefits accurately and clearly describe benefit coverage for mental health parity diagnoses/conditions, distinguish between parity and non-parity coverage, and describe how enrollees can obtain both parity and non-parity mental health benefits.</li> </ul> <p>However, the Healthy Families Combined Evidence of Coverage and Disclosure Form could be confusing to members in regard to the description of services for Severe Emotional Disturbances of Childhood. In addition, anorexia nervosa is omitted from the list of diagnoses covered as "Severe Mental Illness." It appears that this omission was inadvertent as other Plan documents list all diagnoses correctly.</p> <ul style="list-style-type: none"> <li>Enrollees access care by calling a toll-free telephone number. An intake coordinator verifies eligibility, conducts a brief screening, and may discuss provider selection. The enrollee is given a referral to their provider of choice (if they have one) or is given the names of several providers from which to choose. If the member exhibits any signs of distress or is not certain what kind of service is needed, the intake coordinator transfers the enrollee to a triage and referral care manager.</li> <li>The Delegate addresses crises by requiring that inpatient facilities provide care 24/7. A subset of the facility network accepts involuntary admissions. The Delegate also has a subset of office-based providers who accept crisis referrals (non-life-threatening emergent and urgent) on a differential fee arrangement. Its triage and referral lines operate 24-hours a day, 365 days a year.</li> <li>Services are provided for enrollees with autism spectrum disorders on the same basis as all other diagnoses, i.e. utilizing a combination of risk assessment criteria to determine an appropriate level of care, and evidence-based guidelines to assure that care is appropriate. Speech and language therapy and occupational therapy are not covered as mental health benefits. Therefore, enrollees must access these services through the Plan directly. In practice, this requires that enrollees access these services through the Plan's capitated medical groups that have financial responsibility for these services and to which the Plan has delegated utilization management.</li> </ul>

<p><b>UTILIZATION MANAGEMENT</b></p>	<ul style="list-style-type: none"> <li>Initial authorizations for outpatient care are generally for either 5 therapy visits with a psychologist or master's prepared therapist or for 52 visits (within one (1) year) for a psychiatrist. Following the initial outpatient assessment visit, the provider submits further authorization requests on a request for reauthorization (RFR) form. The Delegate accepts the initial provider diagnosis at face value. Care managers authorize further treatment in accordance with a formal level of care policy evidence-based on a combination of clinical and risk factors.</li> <li>The Delegate provides all authorizations based first on its level of care criteria for both parity and non-parity diagnoses. At the time of first RFR submission, the provider's diagnosis is noted. If it is a parity diagnosis, that fact is placed in the electronic record so that claims examiners will continue paying claims beyond any limitations in the enrollee's benefit plan.</li> <li>All services are also evaluated for medical necessity, using evidence-based clinical guidelines. Reasonable likelihood that the treatment will be helpful must exist, the treatment must be generally recognized and approved by regulation and/or professional organizations, and it must be rendered in the least restrictive environment possible. When questions are raised about medical necessity, or any authorizations are to be denied, authorization requests are peer reviewed by a clinical psychologist or psychiatrist ultimately responsible for making any denial decisions. Clinical psychologists may only deny services for non-physician outpatient therapy, while psychiatrists may deny any services.</li> <li>The Delegate has sub delegated utilization management to two sub delegates that manage utilization for 37% of the Delegate's enrollment. The sub delegates have the authority to issue denials but cannot hear appeals.</li> </ul>
<p><b>CONTINUITY AND COORDINATION OF CARE</b></p>	<ul style="list-style-type: none"> <li>The Delegate's processes to facilitate timely communication between and among an enrollee's mental health providers include the following: <ul style="list-style-type: none"> <li>The Delegate's care managers contact enrollees and practitioners and encourage attendance at follow-up appointments for post-discharge follow up.</li> <li>The outpatient care managers, as part of concurrent review activities, consult with medical directors and make suggestions to therapists for a medication evaluation when a patient has been seen in the outpatient setting without symptomatic improvement.</li> <li>The Delegate posts articles regarding timely communication between practitioners, inpatient units, and with enrollees on its Web site.</li> </ul> </li> <li>The Plan and Delegate have the following processes to facilitate timely communication between and among an enrollee's mental health providers and medical providers:</li> </ul>

**CONTINUITY AND  
COORDINATION OF  
CARE  
(Continued)**

health providers and medical providers:

- The Delegate provides a Behavioral Healthcare Coordination Form on the Web site that mental health providers can use to communicate with medical providers if the enrollee meets one or more of the following conditions:
  - is taking prescribed psychotropic medications;
  - has reported a concurrent medical condition;
  - has a substance abuse disorder;
  - has a major mental illness;
  - was referred by the PCP or other practitioner; and/or
  - if the PCP will be following for psychotropic meds.
- The Plan's ongoing Decision Power program supports their five disease management programs (congestive heart failure, coronary artery disease, asthma, chronic obstructive pulmonary disease, and diabetes), all of which are provided by American Healthways. The Decision Power program consists of registered nurses making structured outbound calls to participants in the disease management programs and receiving calls from the participants when they have questions. During the calls, the nurses routinely screen participants for behavioral health issues. As a result, in 2004, the Plan referred 44 enrollees to the Delegate for further assessment and treatment. Of those 44 enrollees, eight entered into treatment with the Delegate.
- The Delegate assesses the enrollee for relevant medical conditions, meds, and allergies during the intake process.
- Monthly co-management meetings are held between the Plan and Delegate to refine communication and resource location processes and to discuss or troubleshoot any issues or trends.
- The Department reviewed the Targeted Intensive Care Management Program files and determined that the Delegate followed up and coordinated care to meet the enrollee's behavioral, social, and medical needs.
- The Plan has developed and disseminated evidence-based clinical practice guidelines for the following parity diagnoses:
  - Major Depression
  - Panic Disorder
  - ADHD in Children
  - Bipolar Disorder

<p><b>CONTINUITY AND COORDINATION OF CARE</b> <i>(Continued)</i></p>	<ul style="list-style-type: none"> <li>• The Plan annually measures compliance with the major depression guideline, using the HEDIS Antidepressant Medication Management measure. The Plan has implemented the following initiatives to improve performance on this measure: <ul style="list-style-type: none"> <li>▪ educating members and practitioners;</li> <li>▪ giving individual performance feedback to high-volume network facilities;</li> <li>▪ educating care managers about the importance of trying to make sure aftercare occurs within 7 days; and</li> <li>▪ making follow-up calls to members and practitioners encouraging appointment attendance.</li> </ul> </li> </ul>
<p><b>DELEGATION</b></p>	<ul style="list-style-type: none"> <li>• The Agreement for Provider Services, effective July 1, 2000, between the Plan and the Delegate defines the delegated mental health and related services, as well as delegated administrative responsibilities.</li> <li>• Exhibit F of that Agreement, “MHN Performance Standard,” Standard 4.2 “Continuity and Coordination of Care” describes the requirements for monitoring activities related to expectations for collaboration with the Plan on the interface between mental and physical health.</li> <li>• The Agreement also requires Delegate participation in Plan Quality Committee structures. Within those structures, routine activities related to collaboration between the Plan and Delegate include improvement of recognition and treatment of mental disorders by primary care providers.</li> </ul>

## A P P E N D I X C

### LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who participated in the onsite survey at the Plan's administrative office on May 9, 2005 to May 12, 2005:

<b>HEALTH NET OF CALIFORNIA, INC.</b>	
<b>Name</b>	<b>Title</b>
Lance Lang, MD	VP, Senior Medical Director, Quality Improvement
Peggy Haines, RN	VP QI and Compliance
Marshall Bentley	VP, Plan Counsel
Janice Kjell, Pharm.D.	Director, Pharmacy
Janice Milligan	Director, Public Health
Valli Coakley, RN	Director, Health Care Services
Cary Uyemura, Pharm.D.	Director, Pharmacy
Sandy Tuttobene, RN	Director, Appeals and Grievances
Kathy Scolly, RN	Care Manager
Jane Vaughn, RN	Care Manager

<b>MANAGED HEALTH NETWORK, INC.</b>	
<b>Name</b>	<b>Title</b>
Deidre Hiatt, PhD	VP, Quality Improvement
Michael Glasser, MD	Regional Medical Director
Judi Shaffer, LCSW	Regional Clinical Director
Barbara Huchinson, RN	Director, Claims QI
Stephani Sunseri	Manager, Provider Network
Rita Ertman	Manager, Claims
Nancy Cheung, RN	Care Manager for Health Families Inpatient Admissions
Melanie Southern	Care Manager
Kass Scotberg, MFT, CCM	Care Manager
Doris Johnson, RN	Clinical Supervisor

## A P P E N D I X D

### LIST OF SURVEYORS

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The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Name	Title
Lyndol Wilkins	Counsel, HMO Help Center
Tom Gilevich	Counsel, HMO Help Center

MANAGED HEALTHCARE UNLIMITED, INC., REPRESENTATIVES	
Name	Title
Rose Leidl, RN, BSN	Contract Manager
Bernice Young	Program Director
Ruth Martin, MPH, MBA	Parity Survey Team Leader
Patty Nelson, RN, MS, CS, CPHQ	Continuity and Coordination of Care Surveyor
Nikki Cavalier, LCSW, CPHQ	Access and Availability Surveyor
Marshall Lewis, MD	Utilization Management Surveyor
Linda Woodall	Claims Surveyor

## A P P E N D I X E

### STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCIES

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#### A. ACCESS AND AVAILABILITY OF SERVICES

**Deficiency 1: The Plan does not clearly present the differences between the benefits available for parity mental health conditions and the benefits available for non-parity mental health conditions to enrollees who contact the Plan to obtain benefit information or to access services. [Rule 1300.67.2.(g)]**

**Citations:**

**Rule 1300.67.2(g)**

A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

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**Deficiency 2: The Plan does not adequately ensure that the provision of after-hour services is reasonable. [Rule 1300.67.2(b) and Rule 1300.74.72(f)]**

**Citations:**

**Rule 1300.67.2(b)**

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees; ...

(b) Hours of operation and provision for after-hour services shall be reasonable;

**Rule 1300.74.72(f)**

A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set for in Health and Safety Code section 1374.72...

#### B. UTILIZATION MANAGEMENT

**Deficiency 3: Benefit termination letters for Healthy Families enrollees do not clearly explain the reason for termination of services for children who are potentially seriously emotionally disturbed and the process by which the Plan refers these children to county mental health systems for SED evaluation. [Section 1367.01(h)(4)]**

**Citation:**

**Section 1367.01(h)(4)**

... Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing... shall include a clear and concise explanation of the reasons for the plan's decision...

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**Deficiency 4: The Plan incorrectly and inappropriately denies payment for emergency claims.** [Section 1371.4 (b) and (c)]

**Citation:**

**Section 1371.4 (b) and (c)**

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

**C. CONTINUITY AND COORDINATION OF CARE**

**Deficiency 5: The Plan does not monitor and improve the exchange of information between and among medical and mental health providers in a systematic and comprehensive manner.** [Rule 1300.74.72(g)(3)]

**Citation:**

**Rule 1300.74.72(g)(3)**

The Plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network.

## A P P E N D I X F

### LIST OF ACRONYMS

Acronyms	Definition
ADHD	Attention Deficit Hyperactive Disorder
CAP	Corrective Action Plan
DSM-IV-TR	Diagnostic and Statistical Manual—Fourth Revision—Text Revision
EOC	Evidence of Coverage
ER	Emergency Room
FHC	Foundation Health Corporation
HEDIS	Health Plan Employer Data and Information Set
HMO	Health Maintenance Organization
HSI	Health Systems International
ICD-9-CM	International Classification of Diseases 9th Revision Clinical Modification
LCSW	Licensed Clinical Social Worker
MFT	Marriage and Family Therapist
MHN	Managed Health Network
PCP	Primary Care Physician
PMG	Primary Medical Group
RFR	Request for Reauthorization
SED	Seriously Emotionally Disturbed
TICM	Targeted Intensive Care Management Program
UM	Utilization Management

## A P P E N D I X G

### THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

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The following provides detail on the required survey activities and the order in which they are undertaken by the Department, as well as instructions on how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. Table 11 summarizes the survey activities and the corresponding timeframes.

**TABLE 11: FOCUSED SURVEY PROCESS**

<b>SURVEY ACTIVITY</b>	<b>TIMEFRAME</b>
<b>Focused Survey On-Site Visit Conducted</b>	As needed
<b>Preliminary Report due from the Department to the Plan</b>	30 – 50 calendar days from the last day of the onsite visit
<b>Response due from Plan to the Department</b> [Section 1380(h)(2)]  <i>(Include evidence that each deficiency has been fully corrected)</i>	45 calendar days from date of receipt of Focused Survey Preliminary Report
<b>Final Report due from the Department to the Plan</b>	Within 170 days from the last day of the onsite visit
<b>Response from Plan to Department on any matters in Final Report</b>	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
<b>Final Report due from Department to the Public File</b> [Section 1380(h)(1)]	Within 180 days from the last day of the onsite visit

#### Survey Preparation

The Department conducts a Focused Survey of a licensed health care service plan on an ad hoc basis in order to evaluate a plan's compliance with certain Knox-Keene requirements and address specific issues identified by the Department. This Focused Survey specifically evaluates a plan's compliance with Section 1374.72.

Prior to the visit, the Department supplies the Plan with a Pre-Onsite Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the onsite visit. These materials are reviewed by the survey team to provide them with an overview of Plan operations, policies, and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the onsite visit so that these will be readily available for the survey team.

## **Onsite Visit**

During the onsite visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

## **Preliminary Report**

Specific to this Mental Health Parity Focused Survey, the Department provides the Plan with a Preliminary Report within 40 days of the onsite visit. The Preliminary Report details the Department's survey findings and the required corrective actions.

## **Plan's Response to the Preliminary Report**

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

- (1) The Plan's response to the Department's findings of deficiencies;
- (2) The Plan's response to the Department's specified corrective actions, which include a CAP;
- (3) Whether the CAP is fully implemented at the time of the Plan's response. If the CAP is fully implemented, the Plan should provide documents or other evidence that the deficiencies have been corrected; and
- (4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is on the way to achieving compliance. Please include a time schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's Web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the Web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's Web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

### **Final Report and Summary Report**

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response, and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the onsite survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.